STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425024	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Spartanburg	295 East Pearl Street Spartanburg, SC 29303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to administer oxygen (O2) as ordered by the physician for 1 of 4 residents (Resident (R)7) reviewed for respiratory care out of a total sample of 17 residents. This failure had the potential to cause respiratory issues including shortness of breath for residents.Findings include:Review of the facility's policy titled, Oxygen Concentrator, dated 05/11/18, indicated, Objective 1. To provide oxygen to resident in need of supplement. 2. To provide continuous oxygen. 3. To promote ease and efficient oxygen delivery . Procedure . 5. Record oxygen therapy on TAR [treatment administration record] or in EMR. Include rate of flow.Review of R7's undated Face Sheet, located under the Resident tab in the electronic medical record (EMR), revealed R7 was admitted to the facility on [DATE], with diagnoses including but not limited to, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and acute and chronic respiratory failure with hypoxia (too little oxygen reaching the body's tissues). Review of R7's physician's orders located under the Orders tab in the EMR revealed a current order, with a start date of 03/08/26, for R7 to receive oxygen at two liters per minute via nasal cannula continuously as ordered as the resident tolerates every shift related to shortness of breath.Review of R7's significant change Minimum Data Set (MDS), located in the EMR under the MDS 3.0 tab with an Assessment Reference Date (ARD) of 03/09/26, revealed the resident received O2 therapy, and had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated R7 was severely cognitively impaired.Review of R7's current care plan, located under the Care Plan tab in the EMR with a last reviewed/revised date of 03/10/26, revealed the following, Problem: RESPIRATORY: [R7's name] is at risk for shortness of breath r/t [related to] allergies, COPD, CHF. She is at risk of recurrent pneumonia. An approach included in this care plan directed nursing staff to: Administer oxygen therapy as ordered.During observations on 03/25/26 at 8:30 AM, 9:47 AM, and 4:15 PM, revealed R7 was in bed receiving O2 from a concentrator via a nasal cannula at a rate of one and a half liters per minute (L/min). During an observation and interview on 03/25/26 at 4:20 PM, Registered Nurse (RN)1 observed R7 and confirmed oxygen was being administered to the resident from a concentrator via a nasal cannula at a rate of one and a half L/min. RN1 checked R7's EMR and stated the resident had a current physician's order to receive oxygen at 2 L/min, and R7 was not receiving oxygen at the prescribed rate. During an interview on 03/26/26 at 12:40 PM, Licensed Practical Nurse (LPN)2 stated R7's Medication Administration Record (MAR) was where staff documented the administration of the resident's oxygen. LPN2 checked R7's MAR and stated that it specified the resident was to receive oxygen at a rate of 2 liters per minute, and the order was initiated on 03/08/26.During an interview on 03/26/26 at 1:45 PM, the Director of Nursing (DON) stated she was aware that R7 was observed on 03/25/26 not receiving oxygen at 2 L/min as ordered. The DON stated she expected oxygen to be administered to residents at the rate as ordered by their physician.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a medication error rate below five percent during observation of medication administration. The facility had two medication errors out of 27 opportunities, which resulted in a medication error rate of 7.41%.Findings include:Review of the facility's policy titled, Pharmaceutical Services Policies and Procedures Manual, dated 09/21/22, indicated, . 6 For solid medications: . b. Medications not otherwise indicated may be crushed. If Do Not Crush is added to a medication order and the resident needs to have medication crushed, please consult the pharmacy. Review of Meds That Should Not Be Crushed and Pharmacy Technician's Letter/Prescriber Insights, updated April 2025 and located at https://pharmacist.therapeuticresearch, revealed that tamsulosin capsules should not be crushed, chewed, or opened. It is a sustained-release medication designed to be released slowly and crushing it can cause too much of the drug to be absorbed at once, increasing side effects like severe dizziness or hypotension. Capsules must be swallowed whole. Enteric-Coated/Delayed Release aspirin 81 mg should not be crushed. The coating is designed to prevent stomach irritation by preventing the drug from releasing until it reaches the intestines.Review of Resident (R)39's Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R39 was originally admitted to the facility on [DATE], with the diagnoses including but not limited to, non-ischemic myocardial injury (non-traditional heart attack) and retention of urine, unspecified.Review of R39s Physician Orders provided by the facility revealed an order dated 05/02/25, for aspirin delayed release/enteric coated (DR/EC) 81 milligrams (mg) one tablet by mouth daily. Ordered on 02/25/25 was tamsulosin 0.4 mg one capsule by mouth after breakfast. Do not crush.During observation of medication administration on 03/25/26 at 8:56 AM, License Practical Nurse (LPN)1 crushed a delayed release aspirin 81 mg tablet, placed it in apple sauce, and administered it to R39. In addition, LPN1 crushed R39's tamsulosin capsule 0.4 mg, placed it in applesauce, and administered it to R39. During an interview on 03/25/26 at 4:10 PM, the Director of Nursing (DON) was asked if an aspirin tablet, delayed release, and a tamsulosin capsule should be crushed. The DON stated, No, none of those medications are to be crushed. During an interview on 03/26/26 at 8:36 AM, LPN1 was asked why R39's medications were crushed. LPN1 replied, It's what we all do; it's easier to get her to take them when crushed and placed in applesauce.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that oxygen concentrators were maintained in a clean condition and free of debris for 1 of 6 concentrators in use (Resident (R)31) out of a sample of 17 residents. This failure posed a risk of cross-contamination, contaminated oxygen flow, and healthcare-associated infections. Findings include:The facility reported there was no policy on the cleaning and maintenance of oxygen concentrators and no documentation where an outside company came in and serviced the concentrators.Review of R39's Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R31 was admitted to the facility on [DATE], with diagnoses including but not limited to, respiratory failure and congestive heart failure.During an observation on 03/24/26 at 8:56 AM, during first day facility rounds in R31's room, the oxygen concentrator had a brown unidentified substance down the front and other debris on the top and down the front and sides. The concentrator was in use delivering oxygen at two liters by nasal cannula to R31.During an observation on 03/25/26 at 1:50 PM, during facility rounds in R31's room, the oxygen concentrator had a brown unidentified substance down the front and other debris on the top and down the front and sides. The concentrator was in use delivering oxygen at two liters by nasal cannula to R31.During an observation and interview on 03/25/26 at 2:34 PM, the Director of Nursing (DON) and Assistant Director of Nursing/Infection Preventionist (IP), accompanied surveyor to R31's room and to the concentrator with serial number 05C63182 delivering oxygen to R31. The concentrator continued to have a brown substance that was running down the front and sides and other debris. The DON stated, it should not look like that and should be clean.